

The following fees are paid to approved health professionals for completion of the forms:

| | |
|---|-------|
| Completion of both the Health Status Report and Activities of Daily Living Index <i>This includes copies of supporting documents for the principal diagnosis(es)</i> | \$100 |
| Completion of the Health Status Report (if completed separately) | \$80 |
| Completion of the Activities of Daily Living Index (if completed separately) | \$20 |

For physicians who complete one or both forms, please directly bill the Ministry of Health and Long-Term Care using the following OHIP codes:

| | |
|--|--------------|
| Completion of both the Health Status Report and Activities of Daily Living Index | KO50 (\$100) |
| Completion of the Health Status Report (if completed separately) | KO51 (\$80) |
| Completion of the Activities of Daily Living Index (if completed separately) | KO52 (\$20) |

Other approved health professionals should submit an invoice for the applicable fee to the Disability Adjudication Unit at the following address:

Disability Adjudication Unit
Social Assistance and Municipal Operations Branch
Box B18
Ministry of Community and Social Services
Toronto ON M7A 1R3

Health Status Report:

1. Please provide factual objective information for all answers.

| | | | |
|--------------------------|----------------------|---|---|
| Last Name Doz | | First Name Jane | |
| Height 5'4 1/2 | Weight 170 | How long have you known this patient? 5 + yrs | Indicate the number of visits in the last year by checking the most appropriate box. <input type="checkbox"/> 0-5 <input checked="" type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> Greater than 20 |

2. Please complete the chart below, listing the current and ongoing medical, surgical and/or psychiatric condition(s) of the patient, and the impairment(s) resulting from those conditions. Do not list conditions that have been resolved or are not current or not ongoing within the last year.

NOTE: For each condition listed below, you must complete all the columns listed (A-F). This section must be completed or the application cannot be processed.

| | (A) Condition(s) | (B) Impairment(s) |
|----|------------------|---|
| | Lung Cancer | Shortness of breath |
| | example | |
| 1. | Back + Neck Pain | <ul style="list-style-type: none"> • pain - constant, severe • pain radiates to shoulders and down legs/hips |
| 2. | Depression | <ul style="list-style-type: none"> • sad - all the time • cries - frequently • poor attention • no motivation <ul style="list-style-type: none"> • sleep - poor • 4-6 hrs avg. |
| 3. | Anxiety | <ul style="list-style-type: none"> • nervousness - constant • panic attacks when leaving house |
| 4. | | |
| 5. | | |

For your reference, the following definitions are provided:

(A) Condition – is the name of the disease or disease state or diagnosis or syndrome.

(B) Impairment – is the loss, loss of use or derangement of any body part or system or function. Function can be psychological or psychiatric in origin.

(C) Restriction – is the limitation to the activities of daily living arising directly or indirectly from the impairment.

| (C) Restriction(s) | Duration | | (F) Prognosis of Condition(s) |
|---|--|---|--|
| | (D) | (E) | |
| <p>Cannot walk more than 3 blocks before having to stop.</p> <p style="font-size: 2em; text-align: center;">example</p> | <p>Expected to last:</p> <input type="checkbox"/> less than 1 year or <input type="checkbox"/> 1 year or more | <p>and Is</p> <input type="checkbox"/> recurrent/episodic or <input type="checkbox"/> continuous | <p>Is likely to:</p> <input type="checkbox"/> improve <input type="checkbox"/> deteriorate <input type="checkbox"/> remain same <input type="checkbox"/> unknown |
| <ul style="list-style-type: none"> • needs help with lifting + carrying • Climbing 1 flight of stairs hurts, takes 5-10 mins • trouble walking more than 10 mins | <p>Expected to last:</p> <input type="checkbox"/> less than 1 year or <input checked="" type="checkbox"/> 1 year or more | <p>and Is</p> <input type="checkbox"/> recurrent/episodic or <input checked="" type="checkbox"/> continuous | <p>Is likely to:</p> <input type="checkbox"/> improve <input checked="" type="checkbox"/> deteriorate <input type="checkbox"/> remain same <input type="checkbox"/> unknown |
| <ul style="list-style-type: none"> • looks disheveled - poor personal care, not dressing or grooming • difficulty w/ housework - no motivation | <p>Expected to last:</p> <input type="checkbox"/> less than 1 year or <input checked="" type="checkbox"/> 1 year or more | <p>and Is</p> <input type="checkbox"/> recurrent/episodic or <input checked="" type="checkbox"/> continuous | <p>Is likely to:</p> <input type="checkbox"/> improve <input type="checkbox"/> deteriorate <input type="checkbox"/> remain same <input checked="" type="checkbox"/> unknown |
| <ul style="list-style-type: none"> • avoids leaving home - only when necessary due to dr appts or basic needs | <p>Expected to last:</p> <input type="checkbox"/> less than 1 year or <input checked="" type="checkbox"/> 1 year or more | <p>and Is</p> <input checked="" type="checkbox"/> recurrent/episodic or <input type="checkbox"/> continuous | <p>Is likely to:</p> <input type="checkbox"/> improve <input type="checkbox"/> deteriorate <input type="checkbox"/> remain same <input checked="" type="checkbox"/> unknown |
| <p>1 + 2 + 3 Cumulative effect of 1 + 2 + 3: could not tolerate work</p> | <p>Expected to last:</p> <input type="checkbox"/> less than 1 year or <input type="checkbox"/> 1 year or more | <p>and Is</p> <input type="checkbox"/> recurrent/episodic or <input type="checkbox"/> continuous | <p>Is likely to:</p> <input type="checkbox"/> improve <input type="checkbox"/> deteriorate <input type="checkbox"/> remain same <input type="checkbox"/> unknown |
| | <p>Expected to last:</p> <input type="checkbox"/> less than 1 year or <input type="checkbox"/> 1 year or more | <p>and Is</p> <input type="checkbox"/> recurrent/episodic or <input type="checkbox"/> continuous | <p>Is likely to:</p> <input type="checkbox"/> improve <input type="checkbox"/> deteriorate <input type="checkbox"/> remain same <input type="checkbox"/> unknown |

3. Please list medication(s) for the current and ongoing condition(s) listed in question No. 2.

| Conditions | Drug | Dosage | Frequency |
|------------|----------|--------|-----------|
| Pain | Naproxen | 500mg | 1x day |
| Depression | Cymbalta | 60mg | 1x day |
| Anxiety | Ativan | 2mg | as needed |
| | | | |

4. Please add any other relevant information or comments that you think may be helpful in assessing the applicant's main condition(s) and impairment(s).

- Meds trialed in past: Codeine (allergic); Celexa (no benefit); Effexor (no benefit)
- Current pain medication not effective at reducing pain to functional level
- Ativan side effects include severe drowsiness

5. Please list hospitalizations related to the current and ongoing condition(s) identified in question No. 2.

| Name of Hospital | Location (Town) | Dates of admission/date of ER visits (year only) relating to the principal condition(s) | <input type="checkbox"/> Hospital Report Attached <input type="checkbox"/> Discharge Summary Reasons for admission and ER visits and length of stay, if applicable. |
|--------------------|-----------------|---|---|
| Belleville General | Blvl | Jun/15 | Panic attack - ER visit - no report available - discharged with Ativan. |
| | | | |
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6. If there are supporting documents for the condition(s) and Impairment(s) listed in question No. 2, please indicate the reason and attach copies. Do not send actual x-rays, pathology slides, etc.

- Laboratory Report(s)
- Pathology Report(s)
- Hospital Report(s)
- Psychological/Psychiatric Assessment
- Speech Language Pathologist's Report

- X-ray Report(s) + MRI
- Specialist's Report(s) - pending referral
- Discharge Summary(ies)
- Audiologist's Report/ENT
- Ophthalmologist's/Optomestrist's Report

Please note that the absence of supporting documents, especially consultant's notes, will delay adjudication.

7. Please indicate, and comment on, the management plan(s) for the main condition(s) of impact. More than one treatment may be checked. Please specify dates (month and year is sufficient).

| Treatment | Past | Current | Proposed | Comments (specify for which condition) |
|--|-------------------------------------|-------------------------------------|-------------------------------------|---|
| Medical | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | ongoing visits with myself medications not optimized |
| Surgical | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | pending referral to surgeon |
| Physical/Rehabilitation <input checked="" type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Massage <input type="checkbox"/> Chiropractic | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | patient tried physio - reports "it made things worse" |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Radiation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Psychotherapy <input type="checkbox"/> Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other (Please indicate) <input checked="" type="checkbox"/> Counselling <input type="checkbox"/> Support Group <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Other | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | ongoing counselling with social worker -very limited resources for help with mental health |

8. Intellectual and Emotional Wellness Scale

▷ *It is not necessary to complete this area for persons whose conditions are solely of a physical nature.*
 For each item indicate the most characteristic class for that item where Class 1 represents no symptoms or signs while Class 2 represents minimal symptoms or signs, Class 3 represents moderate symptoms or signs and Class 4 represents severe symptoms or signs. Check one choice only.

| Psychologist's/Psychiatrist's report attached <input type="checkbox"/> Yes <input type="checkbox"/> No Mark "X" for most appropriate description(s) | No assistance from another person is required to complete the activities specified | | Assistance from another person is required in order to complete the activities specified | |
|---|--|--|--|---|
| | Class 1 • No Symptoms or signs | Class 2 • Some safety concerns • Minimal symptoms or signs | Class 3 • Safety concerns • Moderate symptoms or signs | Class 4 • Unsafe • Severe symptoms or signs |
| A Bodily functions (eating, eliminating, sleeping) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| B. Consciousness (attentional focus, levels of consciousness) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| C. Emotion (affect, mood, anxiety and other emotions, associated psychological disturbances, panic phobia) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| D. Impulse control (difficulty with behavioural control) <i>panic attacks</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| E. Lack of insight (grandiosity, <u>excessively negative self evaluation</u> , difficulty in understanding one's own mental health problems) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F. Intellectual function (cognitive disturbance, planning, organizing, sequencing and abstracting difficulties) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Judgement (difficulties anticipating impact of one's behaviour on self and others) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Learning (language processing, mathematics, attention difficulties) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Memory (amnesia, hypervivid flashback, dissociation) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Motivation (depressive avolitional problems) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| K. Motor behaviour (conversion, motor coordination deficit, agitation, retardation and compulsions) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Perception (visual processing, hallucination, illusion, dissociation, sensory distortions, <u>pain amplification</u>) <i>↑ pain</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| M. Thinking (delusions, obsessions, flight of ideas, blocking) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Auditory/Hearing Impairments:

Audiogram attached

10. Only complete this area for persons who have a hearing problem of any significance.

1. How and when did the person's hearing loss begin?

2. Is the hearing loss unilateral or bilateral?

3. In the patient's mother tongue or first language, does he/she encounter difficulty understanding speech in a quiet environment?

4. Does the patient encounter difficulties understanding conversational speech in the presence of background noise?

5. Is the patient able to hear warning sounds, like sirens, car horns, and smoke detectors?

6. Are there safety concerns related to hearing? (Unable to localize sound or direction of approaching vehicles, etc.)

7. Does the patient have a constant, annoying ringing (tinnitus) in his/her ears?

8. Has there been a change in hearing loss over the last 5 years? If so, how?

9. Does the patient wear hearing aids?

10. With hearing aid(s), could or can the patient function normally?

Please fill out this page if you are completing the Health Status Report *only*.
If you are completing both the Health Status Report and the Activities of Daily
Living Index, please fill out the page at the end of the package.
The application will *not* be processed if the appropriate page is incomplete.

Please complete the following in BLOCK LETTERS.

| | | |
|---------------|---------|-------|
| Name | | Stamp |
| Address | | |
| | | |
| Telephone No. | Fax No. | |

Certificate of Health Professional

I, _____

am a legally qualified _____ in the Province of Ontario

and this report contains my clinical assessment and considered opinion at this time.

Signature

Date

These questions must be completed for all clients.

These questions seek to describe the impact of the impairment on the applicant's ability to attend to his or her personal care, function in the community and function in a workplace. It seeks to understand the restrictions in the activity specified. Please use the scaling below:

| Class 1 | Class 2 | Class 3 | Class 4 |
|--|---|--|---|
| Within normal limits. Or Not applicable. Note: Does not prevent the performance of any activity. | Mild or slight limitations. Note: May result in slightly longer time requirements to complete the task or mild exacerbation of pain. Or Accommodation may be required to complete the task. | Medium or moderate limitations. Or Requires considerably longer time to complete the task and may on some occasions be unable to complete the task with or without accommodations and with or without moderate pain. | Severe or complete limitations on most occasions to completion of the task. |

Mark an "X" through choice

| | | | | |
|---|-------------------------------------|---------------------------------------|---------------------------------------|----------------------------|
| 1. Orientation to time, person and place | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 2. Recognizes within normal limits common dangers in the home, workplace or community | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 3. Ability to comprehend, express or communicate orally | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 4. Use the telephone - <i>nervousness</i> | <input type="checkbox"/> ① | <input checked="" type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 5. Exhibits normal limits of functioning with respect to intelligence | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 6. Exhibits normal limits of functioning with respect to impulse control and behaviour | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 7. Responds within normal limits to situations requiring memory (e.g. remember where he/she lives, names of family and friends, etc.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 8. Attention span is sustainable and appropriate to task | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 9. Physical strength commensurate with person's age and sex | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 10. Ability to participate physically in sustained activity | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 11. Walks three blocks or more on level ground without need to rest | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 12. Climbs up or down one flight of stairs (six steps) | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 13. Able to use means of public transport if available <i>pain ↑</i> | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 14. Wash all parts of the body, able to maintain personal hygiene and grooming <i>no motivation</i> | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 15. Select clothes for weather and situations <i>no motivation</i> | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 16. Bowel and bladder control | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 17. Can take medication(s) as directed and handle/store medication(s) safely | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 18. Is able to utilize commercial services (banks, hydro, phone company, etc.) <i>nervousness</i> | <input type="checkbox"/> ① | <input checked="" type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 19. Financially responsible for his/her own affairs (e.g. applicant can function independently) | <input checked="" type="checkbox"/> | <input type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 20. Able to feed oneself <i>no motivation</i> | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 21. Do housekeeping (cleaning, laundry, meal preparation, shopping for essentials such as groceries, clothes, etc.) | <input type="checkbox"/> ① | <input type="checkbox"/> ② | <input checked="" type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 22. Able to stand | <input type="checkbox"/> ① | <input checked="" type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 23. Able to sit for a sustained period | <input type="checkbox"/> ① | <input checked="" type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |
| 24. Able to transfer to and from chair, toilet, wheelchair, etc. | <input type="checkbox"/> ① | <input checked="" type="checkbox"/> ② | <input type="checkbox"/> ③ | <input type="checkbox"/> ④ |

Please provide any additional limitations you believe to be relevant or additional comments you would like to make. A space is provided below.

client last worked as a server - could not tolerate this work, or any other type of work due to combination of pain, depression + anxiety.

Not attending to personal care

Not able to function in community

Please attach copies of any relevant documentation/reports (e.g. Functional Assessment, Community Assessment).

Please fill out this page if you are completing the Health Status Report and the Activities of Daily Living Index, or the Activities of Daily Living Index only. The application will *not* be processed if this page is incomplete.

Please complete the following in BLOCK LETTERS.

| | | |
|---------------|---------|-------|
| Name | | Stamp |
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| | | |
| Telephone No. | Fax No. | |

Certificate of Health Professional

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am a legally qualified _____ in the Province of Ontario

and this report contains my clinical assessment and considered opinion at this time.

Signature

Date